United States Mission to India

Five-Year Strategic Plan

for the

President's Emergency Plan

for AIDS Relief

2006-2010

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List of Acronyms/Abbreviations/Terms Used

AB	**A**bstinence, **B**e faithful to one partner
ABC	**A**bstinence, **B**e faithful to one partner, use **C**ondoms
AIDS	Acquired Immunodeficiency Syndrome
AMCHAM	American Chamber of Commerce
APAC	AIDS Prevention and Control project
ART	Anti-Retroviral Therapy
ARV	Antiretroviral
AUSAID	Australian Agency for International Development
Avert	Not an acronym: the name of an NGO supported by USAID
BCC	Behavior change communication
BSS	Behavioral surveillance surveys
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CII	Confederation of Indian Industry
CMIS	Computerized Management Information System
COP	Country Operational Plan
CT	Counseling and Testing
DACS	District AIDS Control Societies
DANIDA	Danish Development Corporation
DCM	Deputy Chief of Mission
DFID	Department for International Development (UK)
DOL	United States Department of Labor
DOS	United States Department of State
DOTS	Directly Observed Therapy-Short Course for Tuberculosis
DWCD	Department of Women and Child Development
FDA	United States Federal Drug Administration
FBO	Faith-based organization
FICCI	Federation of Indian Chambers of Commerce and Industry
FMIS	Financial Management Information System
FP	Family Planning
FSN	Foreign Service National
FY	Fiscal year
GAP	Global AIDS Program
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GHTM	Government Hospital for Thoracic Medicine
GOI	Government of India
HHS	United States Department of Health and Human Services
HHS/NIH	HHS/National Institutes of Health
HIV	Human immunodeficiency virus
IACC	Indo-American Chamber of Commerce
IAF	Indian Armed Forces
IDU	Injecting drug user

IEC	Information, Education, and Communication
ILO	International Labor Organization
INL	Office of International Narcotics and Law Enforcement Affairs
INP+	Indian Network of Positive People (INP Plus)
IPC	Inter-personal communication
M&E	Monitoring and evaluation
MCH	Maternal and child health
MOD	Ministry of Defense
MOHFW	Ministry of Health and Family Welfare
MSJE	Ministry of Social Justice and Empowerment
MSM	Men who have sex with men
NACO	National AIDS Control Organization
NACP 1	(First) National AIDS Control Program
NACP 2	(Second) National AIDS Control Program
NACP 3	(Third) National AIDS Control Program
NARI	National AIDS Research Institute
NFHS	National Family Health Survey
NGO	Nongovernmental organization
NIH	National Institutes of Health
ODC	Office of Defense Cooperation
OGAC	Office of the Global AIDS Coordinator
OI	Opportunistic infections
OVC	Orphans and vulnerable children
PHC	Primary Health Care
PHN	Population, Health and Nutrition
PLHA	People living with HIV/AIDS
PPMTCT	Prevention of Mother to Child Transmission
PPTCT	Prevention of Parent to Child Transmission (Indian term for PMTCT)
RH	Reproductive health
RNTCP	Revised National Tuberculosis Control Program
SACS	State AIDS Control Societies
SIDA	Swedish International Development Agency
SOP	Standard Operating Procedure
STI	Sexually-transmitted infection
TB	Tuberculosis
TOT	Training of Trainers
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WHO	World Health Organization

I. Introduction and Background

A. Vision

The United States (US) Mission to India commits its diplomatic resources, technical capacities, and HIV/AIDS development assistance to support the Government of India (GOI), within the framework of the third National AIDS Control Plan (2006-2011), to stabilize the HIV/AIDS epidemic in India.

The USG's strategic priorities for the next five years are:

- To support the Indian National HIV/AIDS Control Program (NACP 3, 2006-2011) to achieve its key objectives for prevention, treatment, care and support, capacity building, and monitoring and evaluation
- To operate as a single program that will integrate the HIV/AIDS activities and maximize the strengths of each USG agency
- Given the available resources, the size of the country and the scale and complexity of the HIV epidemic, to work with other partners and leverage resources to bring programs to scale
- In response to the current state of the epidemic and USG's expertise and experience, to continue to implement prevention programs for the most at-risk populations in states and districts where our program can have the greatest impact
- To promote a sustainable network model that integrates prevention, treatment, care and support services in the public and private sectors
- To support the GOI to build capacity for policy and program development at the national and state level
- To build indigenous capacity for program management and implementation
- To implement programs within the framework of the Three Ones.[1]

B. US Government Targets

The GOI is in the process of determining the national and state targets for prevention, treatment, and care under the next five-year plan, NACP 3. Achievement of these targets will be supported under the Three Ones by more than thirty donor agencies, including the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). In this context, the USG/India's HIV/AIDS program has established the following targets, set out in the table below. The table lists the number of individuals reached directly and indirectly by USG interventions in prevention, treatment, and care in the geographic areas supported by the USG. FY08 targets in some program areas show a decline from FY06 due to closure and consolidation of projects. New programs will be initiated in FY07 and FY08 in the focus states which are expected to lead to increased reach once the new projects are established. The decline in the USG targets for OVC for FY08 also reflects stricter selection criteria following PEPFAR guidance.

[1] The principles of the Three Ones are: one agreed AIDS action framework, one national AIDS coordinating authority, one national monitoring and evaluation system.

Country Targets

	FY2006			FY2008		
	Indirect	**Direct**	**Total**	**Indirect**	**Direct**	**Total**
Prevention – AB # individuals reached through community outreach that promotes A/B	500,000	5,460,000	**5,960,000**	1,000,000	5,300,000	**6,300,000**
Prevention – Other Behavior Change # individuals reached through community outreach that promotes prevention beyond A/B	340,000	4,210,000	**4,550,000**	280,000	3,450,000	**3,730,000**
Prevention – PMTCT: Number of pregnant women receiving HIV counseling and receiving results	270,000	13,000	**283,000**	1,070,000	120,000	**1,190,000**
Prevention – PMTCT: Number of pregnant women provided complete course of ARV prophylaxis for PPMTCT	1,800	500	**2,300**	11,000	3,000	**14,000**
CARE: PALLIATIVE CARE Number of individtuals provided with facility-based, community-based and/or home-based HIV-related palliative care (including those who received clinical prophylaxis and/or treatment for tuberculosis) during the reporting period	5,000	90,000	**95,000**	50,000	145,000	**195,000**
CARE: OVC - Number of OVC served by an OVC program during the reporting period	13,000	39,000	**52,000**	-	30,000	**30,000**
COUNSELING AND TESTING Number of individuals who received counseling and testing for HIV and received their test results during the reporting period	579,500	99,500	**679,000**	980,000	460,000	**1,440,000**
TREATMENT: Number of individuals receiving antiretroviral therapy at the end of the reporting period	15,500	6,200	**21,700**	55,000	13,000	**68,000**
Comments on timeframe, use of regional, country, donor targets, other: See target justification provided in the COP.						

II. The HIV/AIDS Crisis in India

A. The State of the HIV/AIDS Epidemic

India has been battling an HIV/AIDS epidemic since the first case was identified in Chennai, Tamil Nadu in 1986. Since then, the number of HIV-infected persons has increased to an estimated 5.134 million,[2] second only to South Africa. The overall adult prevalence rate is estimated at 0.9 percent. However, 111 of the 600 districts in India have prevalence rates greater than 1 percent in antenatal clinics, up from 49 in 2003. Most of these districts are concentrated in the states of Tamil Nadu, Maharashtra, Karnataka, Andhra Pradesh, Manipur, Nagaland, and Mizoram – with a combined population of approximately 300 million.

The epidemic in India is considered to be a concentrated epidemic and the GOI estimated in 2003 that there are 1.63 million infections among high-risk groups, including 1.5 million in persons with sexually transmitted infections (STI); 71,000 in female prostitutes, and 10,300 in injecting drug users (IDUs).[3] Sexual transmission accounts for over 85% of HIV infections in India,[4] especially in the south and west. Sex with prostitutes is an important driver of the epidemic, and in the North East, the epidemic is fueled by intravenous drug use. The extent to which the behavior of men who have sex with men (MSM) contributes to the epidemic is not known. An increasing number of individuals who are perceived as low risk are becoming infected, especially women and youth. The ratio of infected women to infected men is increasing: the National AIDS Control Organization (NACO) estimates that 40 percent of new infections in 2004 were in women.

There is substantial variation in HIV prevalence among and even within states. There is evidence that HIV prevalence may have stabilized in Tamil Nadu, but it is increasing in other states, especially Maharasatra, Karnataka and Andhra Pradesh. Pockets of higher prevalence ("hot spots") are emerging in northern states, where overall HIV prevalence has previously been reported as low. These states with their large populations, weak public health infrastructure, low status of women, and low literacy levels are highly vulnerable. In the remote states in the North East, bordering Myanmar, drug use is driving the epidemic. Response to the epidemic in this area is a major challenge, given the civil unrest and weak infrastructure in this area.

By March 2005, a total of 103,857 AIDS cases had been reported nationally. More than 45 per cent of these were from Tamil Nadu. However, it is a passive reporting system, and NACO recognizes that AIDS cases are severely underreported.

National sentinel sero-surveillance for HIV infection began in 1994 in 55, mainly urban, antenatal clinics. This has since expanded into a national network of over 700 sites. Interpretation of national surveillance data is challenging because of the size and diversity of the population and different epidemic patterns. The program will be supplemented by surveillance

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[2] NACO 2004 sentinel surveillance report

[3] NACO 2003 sentinel surveillance report

[4] Perinatal transmission and unsafe blood and blood products each account for 2-3 percent of transmission. Male-to-male sex accounts for an undetermined share of transmission.

activities that will more closely monitor the spread of infection from the high risk and vulnerable groups to the general population. Additional information will come in 2006 from the third round of the National Family Health Survey (NFHS 3) which, for the first time, will collect both behavioral and biological indicators for HIV/AIDS for both men and women. The Gates Foundation began a program to study HIV prevalence and incidence among prostitutes and truckers in selected high-prevalence states in 2005.

A national Behavioral Surveillance Survey (BSS) was carried out in 2001-2002 for the general population and high risk and bridge populations (female prostitutes and their clients, MSM and IDUs). The GOI plans to carry out a second national BSS in 2006, and a number of states have conducted their own surveys. The USG has supported nine rounds of behavioral surveillance in Tamil Nadu and two rounds in Maharashtra, as well as two rounds to assess the prevalence of HIV and selected STIs in Tamil Nadu. The 2001-2002 BSS reported high awareness of HIV/AIDS transmission but poor understanding about prevention interventions. These surveys have provided important information for developing evidence-based prevention programs.

Stigma and Discrimination

HIV-related stigma remains strong in India, contributing to secrecy and denial about the epidemic and deterring access to prevention and care services. Stigma is further compounded by the association of HIV with socially unacceptable and/or illegal behaviors among marginalized populations. Prostitutes and injecting drug users are frequently isolated, fearful of authority, and hard to access, compromising effective interventions. High-risk groups also tend to avoid health services supported by both the government and non-governmental organizations (NGOs), since many are not responsive to their needs.

Women are particularly vulnerable to stigma, which can limit their access to information and services. At the root of the vulnerability of women is their low social status, resulting in the imbalance of power between the sexes, which limits safe sex decision making.

B. The Government of India Response

A National AIDS Committee was established in India after the first case of AIDS was identified in 1986. In 1992, this committee became the National AIDS Control Organization (NACO), established within the Ministry of Health and Family Welfare (MOHFW). The first National AIDS Control Program (NACP 1), 1992-1999, focused on general awareness and blood safety. State AIDS Control Societies (SACS) were created in 1999, based on the model of Tamil Nadu, as part of the second National AIDS Control Program (NACP 2) and are now established in all 35 States and Union Territories.

NACP 2 began in 1999 with a $191 million loan from the World Bank. Its main objective was to strengthen responses at the state level through a decentralized program focusing on those at greatest risk of infection, with preventive interventions for the general population, provision of low cost care, institutional strengthening and capacity building. The plan targeted high-prevalence districts (predominantly in urban and peri-urban areas) with education and awareness raising for low-prevalence, mainly rural, areas.

NACP 2 did not include provision of antiretroviral (ARV) treatment but this has become feasible as antiretroviral drugs became more affordable in India and worldwide. In April 2004 the government initiated the national Anti Retroviral Therapy (ART) program. The program's goal is to provide free ARVs to 180,000 HIV-positive people by 2010. This program is now funded in part by the GFATM (Rounds 2-4).

In the last year the commitment of the Indian Government to HIV/AIDS has increased. A National AIDS Council has been established in the Prime Minister's Office. This has multisectoral representation from government ministries, NGOs, and other stakeholders, including the national network of HIV-positive people. The Prime Minister speaks publicly about HIV/AIDS, GOI funding for HIV/AIDS has increased, and NACO has funded an intensified national AIDS awareness and education campaign. NACO has also encouraged the SACS to facilitate intersectoral coordination at the state level.

The GOI's major achievements are the following:

- A decentralized response in which states plan and implement HIV/AIDS control programs
- Development of a policy for blood safety and licensing blood banks
- A nationwide HIV sentinel surveillance system that, while limited, continues to improve capacity to track the epidemic
- A robust NGO-led intervention program focused on high-risk groups involving over 1000 NGOs and community-based organizations (CBOs)
- An expanding network of 700 public sector counseling and testing (CT) centers
- A national computerized management information systems (CMIS) and financial management information systems (FMIS) to assist national and state-level units to monitor their programs
- The development of a forum for the partner agencies to share information and facilitate better coordination of HIV/AIDS control activities

However, fiscal and policy commitment and absorptive capacity needs to be strengthened significantly at all levels. The annual GOI and donor allocations for HIV/AIDS to the national program totaled approximately $170 million in 2004**.** It is difficult to estimate the total contribution from the GOI at all levels, since states contribute substantially in terms of provision of infrastructure and staff time.

The Third National Five-Year Plan for HIV/AIDS Prevention (NACP 3) 2006-2011

In 2005 the GOI, launched planning for NACP 3, 2006-2011. Participation of the USG and over 30 multinational agencies and donors in the NACP 3 planning process has greatly informed the development of this strategy. Fortuitously this process provided guidance and a basic underpinning for the development of this USG five-year strategic response plan.

The evolving NACP 3 has four principal objectives:

- Prevention of new infections, through saturation of targeted interventions for high-risk groups/high-risk areas and scaling-up interventions among other vulnerable populations

- Increasing the proportion of PLHAs receiving care, support and treatment services
- Strengthening capacities at district, state, and national levels, through strengthening infrastructure, systems, and human resources
- The establishment of one nationwide monitoring and evaluation system.

The Indian Health System

Meeting the demand for high quality HIV/AIDS services for a population of over 1 billion is a challenge. As in the US, health care is a state responsibility: states finance and manage health care delivery, including HIV/AIDS services. Under NACP 3, responsibility for implementing programs will be further decentralized to the district level. At the central level, the MOHFW has overall responsibility for health policy and planning and provides resources for centrally-funded health programs, including tuberculosis (TB) and HIV/AIDS. NACO, which falls under the MOHFW, manages and disburses resources to the states for HIV/AIDS activities.

India has an extensive public sector health care delivery network, with around 220 medical schools, 600 district hospitals, 2500 community health centers, 22,000 primary health centers, and 136,000 sub-centers. The primary health care system (funded by the GOI) is complemented at the village level by a separate system of *anganwadi* (community-level) workers, who provide health education under the direction of the Department of Women and Child Development (DWCD) in the Ministry of Human Resource Development. Coordination between these different systems is needed to integrate HIV/AIDS prevention and care into rural programs. In urban areas, health is the responsibility of each municipality. The GOI recently announced a new National Rural Health Mission (or Prime Minister's special initiative) that will refocus attention to the 70 percent of India's population living in rural areas. This will incorporate HIV/AIDS prevention.

However, approximately 80 percent of health care is provided by the private sector, including provision of services from the corporate sector and by private practitioners, both allopathic and practitioners of traditional systems of medicine. Networks of faith-based, private and for-profit hospitals and clinics have been largely untapped in the response thus far. Most private practitioners have not been trained on HIV/AIDS. While public sector investment in health is 0.9 percent of gross domestic product (GDP), the overall investment including private expenditure, amounts to 5 percent of GDP, comparable to Russia and China.

The Multisectoral Response

The MOHFW has established a committee of more than 14 ministries and public sector organizations to facilitate allocation of resources for HIV/AIDS activities in their individual annual plans. NACO is working closely with the Ministries of Education, Human Resources Development, Railways, Defense, Home Affairs, Transport, Rural Development including Panchayat Raj (local self government and municipal bodies) and with public sector undertakings such as the Steel Authority of India, the Employee State Insurance Corporation, National Radio and Television and others. Over the next five years, NACO plans to work closely with a total of 36 ministries to ensure their active participation and sustained commitment to the national program.

Greater coordination of USG agencies will facilitate assistance to those Ministries dealing with areas related to HIV/AIDS. For example, DWCD coordinates all issues relating to the development of women and children through its framework organizations. The Ministry of Social Justice and Empowerment (MSJE) provides funding to over 400 drug abuse rehabilitation NGOs in India. The MSJE also administers the Juvenile Justice Act, which provides services for children in need of care and protection, including rescued trafficking victims and groups vulnerable to trafficking and injecting drug use, such as runaways and street children. The US Department of State's (DOS) Office of International Narcotics and Law Enforcement Affairs (INL) works with both of these ministries. The Ministry of Defense (MOD) operates a separate health care system for military personnel and employees and their families. The MOD has its own training facilities, and currently provides ART to personnel through its health care system.

Leading industries such as the Tata Group and Ford Motors have established HIV/AIDS programs for their workers, in Tata's case this was in response to a number of deaths in their workforce due to AIDS. Indian business associations, in particular the Confederation of Indian Industry (CII) and the Federation of Indian Chambers of Commerce and Industry (FICCI) are actively promoting HIV/AIDS policies and programs. But overall, the response from business and industry needs to be strengthened.

C. The US Government Response

The USG was one of the first donors to implement HIV/AIDS programs in India. Under the Emergency Plan, the US Ambassador to India will lead and coordinate the USG response.

The flagship projects of the US Agency for International Development's (USAID) are the AIDS Prevention and Control (APAC) Project in Tamil Nadu, with activities starting in 1995, and the Avert Society Project in Maharashtra, which began implementation in 2001. These models for bilateral USAID assistance focused on HIV prevention in high-risk behavior groups through support for the SACS and community-based organizations. Both projects also incorporate care and support activities in their programs and together support over 130 NGOs in HIV/AIDS prevention, care and support activities. USAID also supports a program in twelve port cities in eight states, targeting truckers and prostitutes in and around the ports through interpersonal education, and provision of CT and STI services. USAID has taken a lead role in promoting the needs of orphans and vulnerable children (OVC) in India and is supporting thirty projects for OVCs nation-wide.

The US Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), Global AIDS Program (GAP) established a program in India in 2001 to build capacity and strengthen infrastructure for prevention, care and treatment programs. CDC has programs in Tamil Nadu, Maharashtra, and more recently in Andhra Pradesh, Manipur and Nagaland. The CDC-supported program at the Government Hospital for Thoracic Medicine (GHTM) in Chennai is a networked system of treatment and referrals for care. GHTM is one of four designated national ART training centers in the country and recognized by NACO as a Center of Excellence for training. A partial list of leveraging partners at this institution includes the Clinton Foundation, the Gates Foundation, GFATM, and WHO, as well as local Indian NGOs, including the Indian Red Cross and Hope Foundation.

The US Department of Defense, working through the US Pacific Command's Center of Excellence in Disaster Management and Humanitarian Assistance and the US Office for Defense Cooperation (ODC) provides equipment and technical assistance to support the GOI's extensive HIV/AIDS program within the Armed Forces Medical Services. The program has upgraded laboratory facilities, provided test kits, trained laboratory and medical staff and supported prevention workshops.

The HHS/National Institutes of Health (NIH) supports and builds capacity and infrastructure for HIV/AIDS research in India. Currently there are thirty HIV-related NIH grants, with a total funding of around $35 million, of which approximately $10 million is for Indian investigators. HHS also plays a leading role in supporting the Indo-US Vaccine Action Program and works with the HHS/Federal Drug Administration (FDA) to guide Indian manufacturers through the FDA expedited review process for ARVs.

The INL Office provides assistance to the GOI to control narcotic and psychotropic drugs, both used by India's IDU population, and works to promote HIV/AIDS in the private sector. The DOS Public Affairs Office works with the media to promote HIV/AIDS awareness, and conduct outreach programs among youth. The three US Consulates support USG programs in their regions, including the promotion of greater involvement from the private sector. The US Department of Labor (DOL) provides 80 percent of the funding for the International Labor Organization's (ILO) workplace interventions. The USG has also provided funding from USAID Washington-based projects to support HIV/AIDS interventions in India.

D. The International Donor Response

More than thirty donors have come together to assist the GOI in NACP 3. Most organizations support programs in specific states but some provide assistance nationwide. The level of resources required to support NACP 3 is under discussion. Some of the key donor contributions and program areas are:

- The **World Bank** provides overall support to NACO. In 1997, the GOI obtained a loan of $191 million to support NACP 2. The GOI is currently preparing a proposal for World Bank funding for NACP 3.
- **The Global Fund to Fight AIDS, TB and Malaria** (GFATM) has provided three grants related to HIV/AIDS: $100 million in Round 2 for a comprehensive PMTCT care package, including support for access to ART, to be delivered through public-private partnerships; $16 million to scale up and co-locate counseling and testing and TB services in Round 3, and $180 million to scale-up ART services in Round 4. Overall supervision of the Global Fund and proposal preparation are carried out through the County Coordinating Mechanism (CCM), chaired by the Secretary of Health, with the Director of the Indian Network of Positive People as vice-chair. In response to concerns that representation of civil society and the SACS was inadequate, the CCM included state-level representatives and broadened the representation from civil society. A Secretariat for the Global Fund has recently been established, but there are critical needs for additional technical and financial management support, especially at the state level. A major concern is that disbursement of funds has been slow and USG is working with the GOI, Global Fund, and other partners such as WHO and the Clinton Foundation, to develop systems to address this bottleneck. USG will continue to

be active in the CCM and on technical advisory committees to help in proposal development and program implementation and monitoring. With additional resources, USG could help to strengthen oversight at the national level and provide technical support and build capacity at the state level for implementation.

- **The Department for International Development** (DFID) supports targeted intervention activities in high-risk groups and capacity building of SACS in the states of West Bengal, Kerala, Andhra Pradesh, Gujarat and Orissa. DFID has plans to expand the program to fund activities in Uttar Pradesh and Bihar. DFID is exploring the possibility of pooling funding with the World Bank for NACP 3. DFID also contributes to the HIV component of NFHS 3 and Information, Education, and Communication (IEC) activities through the BBC World Service Trust.
- **UNAIDS and UNDP** provide support for advocacy, capacity building, social mobilization and mainstreaming HIV/AIDS. UNDP is the Chair of the Expanded UN Theme Group.
- **The World Health Organization** (WHO) provides technical support to NACO for the development of guidelines, HIV/AIDS surveillance, HIV/AIDS treatment and care, and TB/HIV. WHO supports the Global Fund Secretariat.
- **The ILO** works with unions and the corporate sector to promote workplace interventions.
- **UNICEF** heads the UN Theme Group sub-group on Communication and Advocacy and is providing technical leadership in PMTCT and OVC.
- **The Bill and Melinda Gates Foundation's** Avahan Project is a five-year program that focuses on implementing targeted interventions among high-risk groups (prostitutes and their clients, truckers, IDUs, and bridge populations) in over 70 high prevalence districts in six states: Andhra Pradesh, Tamil Nadu, Karnataka, Maharashtra, Manipur and Nagaland. Avahan is taking an active role in advocating with the corporate sector for HIV/AIDS programs.
- **The William J. Clinton Foundation** provides technical assistance and support for laboratory monitoring and for training private sector health care workers for ART services.
- **The Initiatives Foundation**, founded by Richard Gere, primarily works with the media on HIV/AIDS prevention.
- **Other contributions** to the fight against HIV/AIDS in India have been made by several donors, including the Danish Development Corporation (Danida), the Canadian International Development Agency (CIDA), the Swedish International Development Agency (SIDA) and the Australian Agency for International Development (AusAID).

III. Critical Interventions in the USG Five-Year Strategy

The geographic focus of USG HIV/AIDS investments will balance competing needs across different regions and states within India with the USG's comparative advantage:

- In the high-prevalence states of Maharashtra, Tamil Nadu,[5] and Andhra Pradesh, the USG will deepen collaboration across USG agencies and with the SACS, the District AIDS Control Societies (DACS) and other donors to scale-up comprehensive, integrated,

[5] Activities in Tamil Nadu will also include the adjacent city-state of Pondicherry.

prevention, care and treatment services. In consultation with the GOI, the USG is likely to expand programming to one additional high-prevalence state.

- In the North East, the USG will provide technical assistance to support the expansion of GOI and partner-funded care, support and treatment, complementing prevention activities supported by other donors.
- Over the five-year strategy period, the USG is likely to expand into HIV/AIDS "hot-spots" in one of the vulnerable states, based on our understanding of the progression of the epidemic and available resources,

Within the strategy, the USG will implement a comprehensive approach to HIV/AIDS that strengthens the prevention to care continuum. The USG will work to build the capacity of state programs to provide a networked system of prevention, care and support as the national ART program expands to the district level. The USG will provide training and infrastructural support at selected tertiary and secondary health centers, strengthen referrals to care and support systems, and strengthen the delivery of prevention messages through clinical services and community support organizations. The system will bring together the public and private sectors to provide a range of linked services. As the USG works with the GOI to develop and expand a networked model of services, results and new practices will be shared with other donors through the donor Consortiums set up by the SACS in each of our focus states and through the USG's membership in technical working groups at the national level. We expect the process of replication to unfold gradually: we have already carried out joint site visits in Maharashtra to initiate discussions on identifying project sites and potential partners. Similar processes are planned for Andhra Pradesh and Tamil Nadu.

Led by the US Ambassador, the USG will expand private sector involvement, focusing on promoting corporate social responsibility and greater financial commitment. In collaboration with the CII, the US Consulates in Mumbai, Chennai, and Kolkata and individual US agencies (including USAID, INL, and DOL) have supported a series of meetings to promote corporate social responsibility; and provided technical assistance for the development of HIV/AIDS workplace policies and programs. The US Mission's workplace policy launched on World AIDS Day 2004 has been a powerful advocacy tool that influenced NACO to develop a similar policy for its staff. The Indo-US Private Sector Initiative, announced at the meeting in July 2005 between President Bush and Prime Minister Manmohan Singh, included a provision to set up a Private Sector Capital Fund for HIV/AIDS to receive and manage contributions from the private sector. The Fund is expected to be operational by 2006.

The USG plans to integrate HIV/AIDS activities into all its health and development programs in USG focus states as appropriate. For example, USAID's Population, Health and Nutrition Office (PHN) will work with the USAID Office of Social Development to reach youth at risk; with other family planning and reproductive health (FP/RH) programs to expand access points for PMTCT; and with the Office of Economic Growth to strengthen HIV/AIDS interventions by municipalities. The USG will explore ways to work more closely with other USG agencies, including HHS/NIH, and USG/DOL.

The GOI has recognized individual USG programs as best practices: the APAC Project leadership heads the GOI's Strategic Working Group on targeted interventions and has trained

NGOs from several other states. APAC hosted the 2005 National Workshop on Behavior Change Communication (BCC). The GHTM is recognized as a center of excellence for the GOI ART program and for training in HIV/AIDS diagnosis and treatment. The USG will continue its focus on improving quality and accountability through supporting the dissemination and use of universally accepted standards for service delivery, standardized data collection, quality assurance, and improved monitoring and evaluation systems. Key to this is building the capacity of NGOs, SACS and the GOI to develop effective interventions.

USG programs are being implemented through a diverse portfolio of partners that includes approximately 200 NGOs. We will broaden the range of USG partners to increase collaboration with the private sector and faith-based organizations (FBOs). It is especially important to work with organizations involving People Living with HIV/AIDS (PLHA) at local, state and national levels to counter stigma and discrimination. The USG will assist these organizations to expand their reach, strengthen their linkages to treatment, care and support and build their capacity to take a leadership role in the national and state programs.

A. Strategies for Prevention

Because India is a low prevalence country with a concentrated epidemic, HIV/AIDS prevention will remain a priority within the USG HIV/AIDS strategy. USG programs will contribute to the NACP 3 prevention goals to saturate coverage of high-risk groups through targeted interventions and expand programs for other vulnerable populations. The USG will coordinate closely with the SACS and other donors supporting prevention programs and will transition well-established NGO partners with significant capacity to direct support from the SACS or other donors.

The following are the key elements of the Prevention Strategy:

1. Abstinence and Be Faithful

Abstinence and fidelity are important Indian cultural values. Unfortunately, national data are limited and not yet available for unmarried women. For many married women, age at first intercourse is very young and associated with older male partners. NFHS 2 (1998-99), a survey of married women, reported a median age of 18 for first cohabitation for those aged 20-24: in the same group, 24% of women were married by age 15 and 50% by age 18. The study noted that there were considerable differences across states. The 2004 BSS of male university students in Andhra Pradesh reported a median age of 16 for first sex. National surveys have continued to show wide variability in levels of knowledge and awareness of HIV/AIDS among the general population, particularly among youth.

The USG will scale-up interventions to reach vulnerable youth, especially out-of-school youth and youth in slum populations. Peer educators and outreach workers will be trained to develop their skills to better engage young people for education on AB. The USG will also support interventions for in-school youth where both need and opportunities for strategic leveraging of other resources exist. Interventions with youth will address the gender and power issues that place both young women and young men at risk of infection and will

engage youth in the response to HIV/AIDS. The USG will work in partnership with GOI and other donors to increase knowledge, particularly of HIV prevention methods. It is clear that many OVC are at particularly high risk of sexual exploitation and experimentation, the need for HIV prevention programs for OVC is discussed in the OVC section below.

A high priority for the USG will be to target men with messages about sexual responsibility, fidelity and partner reduction—the "B" in ABC. The USG will use multiple communications approaches to encourage both young single men and married men to avoid high-risk behavior. In USG focus states, programs will work with truckers on major highway routes, industrial workers, and port and dockworkers, sailors and day laborers in major port areas. The USG will also support workplace prevention initiatives that target men, and will work with women's self-help groups and their spouses. The USG will also promote the AB message as part of ABC interventions for migrant labor working in the informal sector in urban areas in USG focus states, recognizing that migrants often engage in sexual risk-taking, acquire HIV and in turn infect their spouses in their home villages. In the city of Mumbai in Maharashtra, USG-funded programs will target international migrants from neighboring countries with prevention interventions, for example, migrants from Bangladesh and Nepal.

2. Scaling Up Targeted Prevention Interventions for High Risk Groups

The USG will further expand prevention interventions for most-at-risk populations, including prostitutes and their clients, truckers and other transport workers. Successful approaches to reaching these populations will be expanded and replicated in new geographic areas within focus states. Since many prostitutes (both female and male) in India are non-brothel based, approaches such as mapping the networks for reaching clients will be expanded as a way to identify those at risk. Recent studies have shown the need to continue high-risk interventions at the same intensity. The 2004 BSS in Tamil Nadu suggests that partner reduction and increases in condom use have plateaued in some groups following earlier positive behavior change. The national BSS (2001-2002) showed that condom use varied greatly with different types of partners. Among prostitutes, condom use at the last sex was 76 percent with paying clients and 39 percent with non-commercial or regular partners. Both IDUs and MSM report similar patterns of behavior.

These interventions will be centered in community outreach, interpersonal communication, and peer counseling, supported by community media. Alternative income-generation activities and savings programs, often linked to education for prostitutes' children, will be continued. Supportive interventions will also include condom education, promotion and distribution, especially in high-risk venues and groups. The USG will work closely with commercial and social marketing agencies as well as NGOs that work with at-risk groups. The two will collaborate to identify and stock outlets (for example, brothels, bars, motels, and truck stops) that are easily accessible to such groups. Condoms will also be emphasized for prevention among discordant couples. BCC programs will promote a mix of ABC messages appropriate to the target populations, including a mix of B and C messages for mobile men. The social acceptability of alcohol and its abuse is a challenge and will be addressed through BCC. Behavior change programs for high-risk groups will include

messages to promote the use of counseling and testing services. For those who test positive, the linkages between counseling and testing and care and treatment programs will be strengthened.

While interventions among prostitutes are fairly well established in India, programs among MSM urgently need to be scaled up. Current reports suggest that MSM behavior could be a significant avenue for HIV transmission. Many MSM do not self-identify as gay or bisexual and also have sex with women. However, due to high stigma MSM may be reluctant to access services. The strategy will focus on MSM peer-led interventions, drop-in centers, expanding outreach to *hijras* (eunuchs) and other MSM subgroups, improving access to young men at risk, and increasing support for collection and analysis of MSM seroprevalence and behavioral data. There is growing recognition that the problem of intravenous drug use extends beyond the North East. USG will support programs to better characterize these at-risk populations and support local NGOs to build peer-driven behavior change programs. IDU programs will be strengthened through a coordinated approach with other stakeholders, such as INL, working with IDUs. Again, it is important to penetrate the social networks of IDUs, involve IDU leaders in peer-driven programs, and promote the use of drug treatment programs, HIV counseling and testing, and primary health services.

In Tamil Nadu, the USG has been supporting targeted interventions for high-risk groups for a number of years. A priority will be to implement an exit strategy with existing partners without undermining gains in HIV prevention to date.

USG activities with the MOD have enhanced HIV prevention activities in the IAF by providing funding for BCC, including peer to peer materials as well as condoms. The USG is further supporting MOD training of HIV care providers and peer counselors. The MOD, with USG assistance, will continue to intensively target prevention services directed at populations at higher risk; those soldiers in deployment in the northwest and northeast, troops garrisoned in high-prevalence areas, and troops involved in peacekeeping operations. Future activities to provide the MOD with enhanced monitoring and evaluation through active surveillance will allow assessment of the efficacy of prevention services. The USG will provide technical assistance for integrating prevention for HIV-positive individuals, especially strategies for discordant couples, into care and treatment programs, including placement of specially-trained counselors in treatment centers.

3. Strengthening Behavior Change

There are still many gaps in our knowledge that impede our ability to do evidence-based programming and the USG will work with GOI and other partners to collect data for information gathering.

Replicating Good Models of Behavior Change: There is an opportunity to identify, disseminate and replicate good models for BCC. Good models should be defined for interpersonal communication (IPC) by paid or volunteer communicators, quality monitoring systems, mix of media and IPC, and for formative research, behavioral monitoring, and applied research.

Addressing Stigma: Eliminating the stigma of HIV/AIDS will be addressed through messages and training that reduce fear and increase personal identification with and understanding of the issues related to PLHAs. The issue of stigma will be expected to be addressed by program managers and trainers in the same way as issues of ABC and gender. PLHAs will be included in providing support and prevention counseling, particularly for HIV positives, and in programs for MARPS.

National and State-Level Capacity Building: The USG will provide technical assistance in strategy development for BCC to NACO. It will also strengthen capacity for HIV/AIDS communication in USG focus states: for example, by helping to develop state-wide communication plans, providing training in BCC, and facilitating opportunities to share lessons learned in communication at the national and state level. The USG will also strengthen the capacity of media, particularly the vernacular media, to report on HIV/AIDS, and support training for business journalists to promote expanded HIV/AIDS interventions in the corporate sector.

4. Prevention of Mother to Child Transmission (PMTCT)[6]

There are approximately 27 million pregnancies annually in India. Surveillance data suggest that approximately 189,000 of these are in HIV-infected women and 56,000 children will be infected annually in the absence of an effective PMTCT program. UNICEF, the lead technical agency in PMTCT, estimates that only 4 percent of HIV-infected pregnant women received ART in 2004. Contributing to this low uptake are the large proportion of women who deliver outside of institutions, the limited engagement of the private sector in programs and the slow implementation of the national program for Prevention of Parent to Child Transmission (PPTCT). Currently PMTCT is available in district hospitals in the six high-prevalence states, but services are poorly promoted and not well integrated with existing Maternal and Child Health (MCH) and Primary Health Care (PHC) services. Under NACP 3, these services will be scaled up to over 400 sites under the $100 million Round Two Global Fund grant.

The USG will contribute to PMTCT programs with its limited funds through leveraging of resources with partners and some direct support to the private sector. The USG will look for opportunities to strengthen the quality of PMTCT services and to increase the demand for PMTCT. Activities will include:

Technical Support and Capacity Building: USG will continue to work with NACO, the SACS, and UNICEF to ensure implementation of the funds for PMTCT provided through GFATM 2. The USG will assist the Andhra Pradesh state government in rolling out the GFATM PMTCT program in selected districts. Over the next five years, the USG will facilitate the integration of high quality services into district hospitals, antenatal clinics, and community and primary health care settings throughout Andhra Pradesh.

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[6] Prevention of Mother to Child Transmission (PMTCT) is the term used in Emergency Plan documents. The GOI uses the term Prevention of Parent to Child Transmission (PPTCT). In this document we use PMTCT, except where we are referring to the names of GOI established bodies.

Strengthening the Private Sector: Since almost 50 percent of women deliver in the private sector, the USG will support direct implementation at a small number of PMTCT sites in the private sector. The USG will also promote the greater involvement of private sector physicians in PMTCT delivery through training programs in high prevalence states. Community programs funded by the USG will provide support through community education and identifying and referring pregnant women for testing in PMTCT programs. As these programs are developed, the USG will ensure that these programs develop a system for tracking referrals and linking with care, support, and treatment programs.

5. Blood and Injection Safety

The USG took a leading role in early blood safety programs in India, and more recently in providing technical assistance and training to strengthen policy and practices on injection safety. Over the period 2006-2011, the World Bank will take the lead in supporting activities that are delineated in the National Action Plan for Blood Safety to ensure safe blood supplies. The USG will not take a major role in these areas. The USG strategy will ensure that universal precautions, including waste management, are included in program activities and incorporated into training curricula.

B. Strategies for Treatment

HIV/AIDS treatment is a comprehensive cycle of services that begins with the referral of patients to appropriate providers, carrying out sophisticated clinical and laboratory procedures, treatment with complex drug regimens and eventual referral of patients to community-based providers for continuing care. This dictates a need for policy guidelines, trained health care providers, treatment protocols, quality laboratory systems, appropriate information systems, robust supply chains, quality counseling and strong support from community-based organizations. A key challenge for the USG is to provide strategic support for these elements with limited resources in an area of enormous need.

The number of HIV infected persons in India and the distribution of these individuals in states with extremely large populations makes the comprehensive support of the treatment program unfeasible. Therefore, the USG strategy will identify and contribute to program areas where its agencies can have greatest impact and collaborate with the GOI and other donors to jointly support the development of high quality services under the national program. The USG will not procure antiretroviral drugs, but will support the GOI to leverage resources for drugs and other costs from the GFATM and other donors.

The following are the key elements of the treatment strategy:

Expansion of the GHTM Model: The GHTM Center of Excellence in Chennai has developed a comprehensive ART treatment and support model that includes: training health care providers, improved laboratory systems, referral procedures, quality assurance programs, information systems for patient tracking, monitoring and evaluation, and close collaboration with PLWA and community organizations for ongoing care and prevention counseling. This model will be introduced in other states, beginning in Maharashtra, where USAID and CDC will implement a joint project that strengthens a center for ART treatment, builds the capacity in surrounding,

lower level institutions for scale-up, and links with community-based groups for ongoing support.

An important feature of the USG treatment strategy is to expand this model to improve the management and treatment of patients at district-level hospitals. USG will provide appropriate laboratory support, information systems and training for public and private sector programs at this level. These institutions will in turn be linked to PHC services and community providers to support adherence to ART and ensure continuity of care. Lessons learned from monitoring and evaluating these programs can provide guidance for the expansion of this model to other states.

Increasing Demand and Access to ART: Some highly vulnerable populations, including prostitutes, IDUs, and MSM are difficult to reach in ART programs. We will train NGOs working with these at-risk groups to increase demand and improve access to ART for these populations. The USG will also work with other district-level services, such as TB, RH, MCH and STI services, which care for patients with HIV infection to include them in the networked model.

Training and Capacity Building: The challenge is to provide appropriate training for people with differing roles in the continuum of care. USG will assist NACO, the SACS and the Armed Forces to develop and implement high quality training programs that incorporate ongoing mentoring for trainees. Training for ART will be given by groups with appropriate expertise. The key groups we plan to train are physicians, nurses, community organizations, counselors and family members. Training will be conducted by professionals at the same level, who have specialist expertise. Training for private sector physicians through USG-supported programs, including the Christian Medical College, Vellore, and other networks will be expanded. The GOI has requested GHTM to carry out monthly training programs to assist in the scale up of treatment. USG will strengthen and expand similar programs in Maharashtra and Andhra Pradesh, and other states as needed.

Technical Support: In collaboration with other agencies, the USG will support the GOI's national program by assisting in the development of policies and guidelines for treatment, supply chain management, quality assurance standards and monitoring and evaluation. The USG will support the development of a minimum data package for patient information that is appropriate for secondary and primary health care facilities and that can feed into the national data system. A major issue is the development of protocols and policies for second-line ART treatment for adults and pediatric treatment.

Pediatric ART: Under the national ART policy, children under 14 are a priority for ART. NACO has established a pediatric desk to address the many challenges that have occurred in meeting this national priority. The National Working Group for Pediatric AIDS is discussing options for better referral, drug formulations and improved monitoring of treatment and care for children. USG will provide technical support for the development of national protocols and guidelines for pediatric ART and CT for children. We will also strengthen linkages from the USG's OVC programs with ART centers. Lessons learned will be documented and shared.

C. Strategies for Care and Support

1. Counseling and Testing

Until recently most CT sites in India have been hospital and clinic based. These were often understaffed, had few clients, lacked trained counselors, were poorly supplied with test kits and the proportion of those tested who returned for results was low. Many existing prevention/behavior change programs have weak or non-existent links with counseling, testing and referral services.

The USG has already contributed substantially to improving the situation. CDC has supported the revision of national HIV CT guidelines and provided technical support and funding to establish three model centers for CT (in the North-East, Maharashtra, and Tamil Nadu) that deliver training for counselors and laboratory technicians. Recent innovations at the GHTM in Chennai have been the establishment of a Family Counseling Center that provides support and testing for family members, and strengthened laboratory and information systems. USAID supports CT services in the USG focus states and has developed strong models of integrated VCT services targeted at high-risk groups in twelve port cities in eight states, including support for 13 stand-alone VCT centers, outreach through mobile units, demand promotion, and Hotlines.

Under NACP 3 the GOI plans to scale up CT services from the current 700 sites to a total of 22,000 over the next five years. NACO's goal is to increase access to CT through decentralization to the primary health care level and expansion beyond hospital and clinic-based sites. Priorities for USG support will be to: increase demand for CT, especially for high-risk groups; increase provider-initiated CT; move towards same-day test results; develop systems to ensure an uninterrupted supply of test kits; standardize training for counselors; improve quality control and regulation of testing in private laboratories; provide post test support groups; and link these systems to a network of prevention and care services.

Increasing Demand: We will incorporate CT within all of our targeted interventions, either implementing it directly or ensuring that high-risk individuals reach clinics and learn their results. We will expand provider-initiated testing, through building provider capacity to identify HIV-related syndromes and refer patients for testing. To do so, we will map and identify CT services accessible to and supportive of high-risk populations, particularly those with STIs and/or TB, and train their staff as needed. USG will provide technical support for the implementation of GFATM Round 3 that co-locates CT and TB microscopy centers. The USG will also implement a media and outreach campaign to increase demand for CT services.

Improved Testing Quality: USG agencies will work to ensure testing quality by training providers in diagnosis, strengthening quality control in laboratories and ensuring that test results are reported back to providers accurately and in a timely fashion. At the national and state levels, USG will build capacity and support the improvement of standards for laboratory diagnosis of HIV infection, and a national quality assurance system. We will also identify key partners in the private sector to develop programs to improve testing quality.

Strengthening the Quality of Counseling: There is an urgent need to improve the quality of counseling in all programs. Therefore, USG agencies will work to standardize the quality and consistency of counseling services and strengthen national counselor curricula, including training in post-test counseling, confidentiality, and family counseling. USG agencies will continue to train counselor cadres and provide training of trainers in counseling in the focus states. Programs to supervise and place counselors in private laboratories will be expanded, as will training programs.

Improved Coordination and Referral for Care: USG programs will strengthen provider-initiated CT and build the capacity of public and private health care providers so that increasingly CT becomes standard practice. Ensuring timely and appropriate referral of HIV infected persons from CT centers to treatment facilities will be strengthened, using proven effective methods for tracking referrals, for example as developed in the Salvation Army model that will be supported by Avert. Training, materials, messages, and selection of target populations will be coordinated among USG agencies providing CT to avoid duplication of effort.

Strengthen family counseling and referral systems: We will scale up the family counseling model established at GHTM. Components of this model include the daily involvement of the Indian Network of Positive People (INP+) in providing support and promoting prevention for positives, contacting and testing family members, and training of counselors for these special settings, with a special focus on discordant couples.

Service delivery in the private sector: USG will continue to support CT services managed by private providers. This includes services in stand-alone CT centers, mobile and community-based services, and laboratory-based services provided by NGOs, private hospitals, and community-based organizations. Capacity-building and support will be provided to ensure that these facilities meet national standards for informed consent, counseling, and quality controlled test results.

2. Palliative Care

One of the key objectives for NACP 3 is increasing access to care and support services for PLHAs. This was in response to the increasing burden of illness being seen, particularly in the higher prevalence states. The NACP 3 Working Group on Care listed the main barriers to quality care for PLHAs. These include too few training programs, a lack of standardized curricula, no clear guidelines for care at different levels of support, neglect of pain relief, and a lack of well-managed system for procuring and distributing quality drugs and laboratory supplies. Most PLHAs do not know their status until they become ill, and stigma and discrimination is rife in medical settings as well as communities.

The USG programs will adhere to and help to create a network model that integrates prevention and care. It will include the following key elements, within the public and private sectors:

Standards of care: National guidelines for HIV care and treatment are not routinely updated and are frequently unavailable. The USG will work with other technical agencies and NACO to review, update and disseminate evidence-based guidelines and standards, relevant to the Indian situation. This will include a standardized training curriculum and a minimum package for home care. The USG will support the introduction of an accreditation system for institutions training public and private service providers and pilot-test the system at the state level.

Building capacity: Depending on available funding, improved laboratory capacity, a strengthened medical records system, and training for medical providers will be expanded at selected tertiary institutions and, in the case of the patient record system, simplified for use at lower level health care providers. The USG will provide technical support and train health providers at all levels in comprehensive skills for HIV prevention, diagnosis, treatment, and care. A major challenge will be to counter stigma among health care providers who are reluctant to treat persons with HIV. The USG will also build the capacity of FBOs and CBOs for comprehensive care and support. Faith based organizations (FBOs) and their contributions to care and support are under-recognized; their activities need to be strengthened and their potential role expanded, publicized, and replicated more effectively. The USG is already working with FBOs and will be expanding these efforts.

Palliative pain care: Access to palliative pain care for HIV/AIDS patients is virtually non-existent, since it is limited by state narcotics laws on dispensing these drugs. The DOS's INL office will promote linkages with drug abuse rehabilitation NGOs, cancer NGOs, and palliative pain care NGOs to encourage states to pass and implement Ministry of Finance regulations dating back to 1997 that reduce the bureaucratic approvals needed to establish palliative pain care programs.

Nutrition counseling: Nutritional support is still an underutilized approach in caring for HIV-infected people. The USG will incorporate nutrition counseling into its training for care and support and will seek out opportunities to work with the World Food Program (WFP) to include nutrition in USG-supported care programs and service delivery programs. The USG is already working with WFP to establish national guidelines on nutrition for PLHAs.

Strengthening the role of PLHAs: The involvement of PLHAs in care and support programs is also weak and underutilized, as are PLHA organizations in many states. The USG will work with PLHA organizations to build their capacity for home-based care and to involve them in managing and delivering family-centred counseling services. Support will be expanded to strengthen district-level PLHA organizations.

Increased private sector involvement: The USG will promote partnerships with the business sector, private sector networks, FBOs and NGO networks to promote the inclusion of HIV/AIDS care in their programs. We will be exploring opportunities to collaborate with UNDP regarding incorporation of HIV treatment and care into Indian health insurance schemes.

3. HIV/AIDS and TB

India has one-third of the world's TB cases and it is the most common opportunistic infection (OI) in persons with HIV in India. The Revised National TB Control Program (RNTCP) is credited internationally with having implemented and scaled up the Directly Observed Treatment – Short Course Therapy (DOTS) to over 90 percent of the country, more rapidly and with higher quality than any other country. In 2001, the RNTCP and NACO developed joint guidelines for managing HIV/TB co-infected patients, including systems for patient referral. The Global Fund Round 3 supports co-location of DOTS and CT centers to increase the proportion of TB patients who are tested for HIV.

While the national TB program has been successful, the challenge is to strengthen linkages and integrate HIV/AIDS treatment and prevention into the TB system, to develop protocols and provide training for health care personnel, and to ensure rational and timely drug distribution at the local level. There is an opportunity for the HIV program to learn from the experience of the national TB program in rolling out treatment therapies, ensuring the drug supply at all levels of the health system, and involving the community in supporting adherence to therapy.

The USG strategy will continue to provide technical assistance to the RNTCP and NACO to strengthen TB/HIV programs at the national, state and local level, and will work with WHO to support the development of guidelines. All USG-supported care and treatment programs will develop systems to track TB referrals and DOTS, including expanding CT services for TB patients and ensuring that patients with HIV are routinely screened for TB. Community and home care programs will establish linkages with local RNTCP clinics and, wherever feasible, become DOTS providers. The DOTS program at GHTM will be strengthened and lessons learned about DOTS, TB diagnosis and ART shared nationally. In a joint activity CDC and USAID are supporting a technical advisor to WHO, India, who will work with the GOI on policy issues, especially in areas of TB/HIV surveillance, provider initiated VCT, and TB/HIV coordination.

4. Orphans and Vulnerable Children

It is estimated that of the 5.134 million Indians living with HIV/AIDS, over 100,000 are children under the age of 18. Many other children are orphaned as a result of HIV/AIDS or live with a parent or care giver who has HIV/AIDS. In addition, India has a large number of children vulnerable to HIV infection. The needs of these children, both those infected and affected by AIDS and vulnerable children, are vast: encompassing safe shelter, food, and clothing, besides health, and most are ignorant of HIV. Little hard data exists on the number of vulnerable children, or on the number directly affected by HIV.

UNICEF and the USG have been the most active donors in this area. USAID provided funding and capacity building to local organizations to initiate and model support for HIV-affected and vulnerable children. USG's program is the largest intervention with OVC in India, and provides care and support, community training, prevention education, and socio-economic support for OVC. The program has developed counseling protocols for children vulnerable to, affected by, and living with HIV/AIDS. NGOs have historically led the

response to vulnerable children. Save the Children and AIDS Alliance/India are also supporting local groups to integrate the needs of children with HIV/AIDS into community development activities. The Lawyers Collective has been involved in reviewing HIV/AIDS legislation related to children.

The USG is supporting OVC interventions through USAID at 22 sites in Delhi, Mumbai, Tamil Nadu, Andhra Pradesh and Manipur and over 12,000 children infected and affected by AIDS are beneficiaries of different services. This program has reached approximately 19,000 children since it was initiated in selected states and is the largest program in India targeting OVC.

A major challenge in carrying out an OVC program in India, a country with a low prevalence epidemic, a high level of stigma, and a large number of children at overall risk, is the difficulty of singling out children infected or affected by HIV/AIDS. The program will seek out opportunities for wrap-around programming, but this will be a transitional process, to ensure continued support for children enrolled in existing USG programs.

In the next five years, the USG strategy will seek to identify the key components for successful OVC programs in low prevalence concentrated epidemic settings. This will be accomplished by reviewing successful models in India. There are many important interventions for providing for OVC. These include: providing counseling; BCC, including an emphasis on AB prevention messages; linkages to support services; involving children directly in programs that reduce their vulnerability through life skills education and livelihood options; community mobilization for providing care and support by training caregivers and home-based care providers; establishing linkages to medical, psychosocial and economic support services and addressing stigma and discrimination in the community. The GOI's ART program prioritizes children with HIV, and the USG will develop strategies to strengthen linkages for children in OVC to existing care and support and ART services.

Advocacy and an overall review of the status of children supported by UNICEF and USG resulted in including OVC for the first time in the national program (NACP 3) and the establishment of a Pediatric Desk within NACO. USG will continue to collaborate with NACO and UNICEF to develop policy and build capacity for OVC.

D. Strategies for Supportive Interventions

1. Policy and Engendering Bold Leadership

For some time there has been strong support at the highest levels of the GOI for HIV/AIDS programs. However this needs to be expanded and extended to the lower levels of government in states, areas of the private sector and community and FBOs. The strategy of the USG will be to focus on key strategic partners using the advocacy role of the US Ambassador and the three US Consulates-General and the technical expertise and resources available from USG staff.

Support for National and State Leadership: In collaboration with other partners, the USG will support NACO in the design and implementation of NACP 3. This will involve:

providing assistance in the development of state and district plans and technical guidelines and protocols, participation and provision of technical assistance to Technical Working Groups, and capacity building training for senior staff and new leadership for the state and district programs. US agencies are active partners in program planning and design, participate in partner consortiums, promote staff development and provide technical support for program management in Tamil Nadu, Maharashtra and Andhra Pradesh.

Developing strong inter-agency collaborations: USG agencies will support NACP 3 through participation in the expanded UN Theme Group chaired by NACO and UNDP, the Country Coordinating Mechanism of the Global Fund, the technical panel of the Bill and Melinda Gates Foundation, and other technical committees such as the OVC Working Group headed by the DWCD. The USG will also seek to enhance its partnerships with groups such as the Parliamentary Forum and municipalities.

Private/Public Sector Leadership: There are good examples of workplace policies and programs in the corporate sector but leadership in general is weak. The USG agencies will reach out to private and public sector organizations and industry associations such as the Indo-American Chamber of Commerce (IACC), the American Chamber of Commerce (AMCHAM), CII, and FICCI through the Embassy, the Consulates, and USG field programs. The objective will be to increase the number of industries and businesses implementing programs for their workforce, expanding their programs to surrounding communities, and working together to develop policies for such issues as health insurance, and employment practices. In particular, the USG will promote the mobilization and direct financial contribution of industries and the private sector in the fight against HIV/AIDS. The recently announced Indo-US Private Sector Initiative of 2005 provides a mechanism through which USG technical input can be used to leverage funding and commitment by the private sector for HIV/AIDS programs.

Engaging the leadership of the private health sector: Engaging the private health sector, which provides about 80 percent of health care in India, is challenging. In order for standards of quality for HIV/AIDS management to be implemented within the private sector, they must be endorsed by the leadership. Therefore, the USG will work with leaders of medical colleges, associations of private hospitals, and medical professional associations to support the adoption of the national standards and guidelines within their own practices and institutions.

Faith-based organizations: The USG has supported several national meetings of faith-based organizations in Delhi, Bangalore and Chennai. USG also recently provided support to the Catholic Bishops Conference to develop their HIV/AIDS policies and strategy. Over the next five years, the USG will reach out more broadly to other faith-based organizations, with a particular emphasis on funding FBOs to provide AB prevention education, support for OVC, and care and support. In 2006, FBOs will be encouraged to apply for grants under a new USG network of care and support organizations currently being developed. In partnership with the Catholic Health Association of India, the USG provides technical and logistical support to implement PMTCT, VCT and OI management in primary health care centers in Andhra Pradesh State.

Strengthening the Leadership of PLHA organizations: For most Indians, HIV/AIDS remains a very distant and unreal threat, while the stigma associated with HIV/AIDS at all levels of society is real and severe. Campaigns that involve persons living with HIV/AIDS have had some success in raising awareness and reducing stigma. PLHA organizations, especially the women's PLHA organization, have benefited from institutional capacity building, including support from the USG. Expanding this program will be a priority for the future. Support will be extended beyond the national organizations to mobilize and provide support to their state networks and local constituencies in partnership with health care providers and other care-giving CBOs.

Scientific leadership: The Mission will explore opportunities for further India-US scientific cooperation in the AIDS arena, as set out in the Indo-US HIV/AIDS Initiative of 2005. The Global Development Alliance will be investigated as a possible avenue for promoting cooperation among public and private Indian research institutions, US universities, other US government agencies (HHS/CDC, HHS/NIH), private foundations and private companies.[7] The objective will be the cultivation of a lasting and evolving Indo-US scientific cooperation relationship that would share training, research and results over the long term and foster even stronger ties between India and the United States.

2. Sustainability and Human Capacity Development

India is in a period of rapid economic growth and social development, and the GOI is increasingly supporting the National AIDS Control Project. Each of the GOI Ministries are being asked to provide some resources to support the program. However, there is still a huge need for outside support for the foreseeable future, if the HIV epidemic is to be contained. There are more than 30 donors providing financial support, but the cost-estimates for NACP 3 have not yet been finalized. It is clear, however, from the funding projections for NACP 3, that GOI, UN and donor contributions are expected to continue.

The USG is committed to developing sustainable systems, in so far as that is compatible with an emergency response to the HIV/AIDS epidemic. In states, such as Tamil Nadu, where we have more than ten years of experience implementing innovative programs in HIV/AIDS, we are engaging the local leadership in using the existing infrastructure to deliver programs. We will also continue to develop the capacity of our many partners to manage and administer their programs. We will develop transition strategies for all of our directly implemented programs. This may include a gradual reduction in resources provided for salaries and other recurring costs, leveraging of resources, transitioning funding to the SACS or state governments, and integrating and mainstreaming program activities within the existing health infrastructure.

The USG will also support programs to strengthen human capacity. There will be greatly increased demand for individuals trained in HIV/AIDS over the next five years. Although

[7] Mission resources could be used to support in-country institutions while Foundation/GDA resources could support U.S. institution requirements.

India has large numbers of trained health care providers and NGOS, many lack the knowledge and skills for successfully managing large HIV/AIDS prevention and care programs. The USG program for human capacity development over the next five years will focus on two main areas: direct training of personnel and building pedagogical skills.

Training curricula used by the different USG agencies and the GOI will be harmonized. We will emphasize training of trainers and identify and strengthen key local institutions to deliver training courses, including activities to evaluate and provide ongoing mentoring to those trained. To strengthen the network approach, we will ensure that supervisors are provided with special skills to mentor their trained staff and ensure new technical approaches are implemented.

3. Laboratory Infrastructure

India has a large infrastructure of clinical laboratories in the public and private sectors but weak or inadequate laboratory services have held back the implementation of programs for treatment and care. Testing is also expensive and restricts access to care for those in need. Although most of the needed laboratory diagnostic kits and reagents are available in India, their effective use is compromised by unreliable cold chains and lines of supply. This means that most patients have limited or no access to quality laboratory services and health care providers are forced to base treatment decisions on clinical judgment rather than laboratory results.

Laboratory strengthening is an essential component of the USG response to HIV/AIDS in India. Its activities are closely coordinated with WHO and the Clinton Foundation. At GHTM, the USG has successfully renovated the hospital laboratory, resulting in an increase in the number treated for HIV, and provided a demonstrated model of a public health laboratory. ODC, on behalf of the Pacific Command, manages a program of laboratory strengthening that supports HIV testing, ART and care for the IAF. NIH research has supported laboratory capacity building and renovation at key Indian institutions.

Over the next five years, the USG will support the development, review, and monitoring of laboratory standards and guidelines; promote laboratory quality assurance programs; and strengthen supply chains and procurement systems for rapid testing programs. Depending on resources available, there will be phased strategic strengthening of laboratories in key tertiary institutions in Tamil Nadu and Maharashtra and in the Armed Forces, especially in the North East, in support of the Indian national ART program and the planned scale-up of care and support activities under NACP 3.

4. Strengthening Coordination and Collaboration

The planning process for NACP 3 demonstrated a level of national coordination and engagement that is unprecedented in India. National, state, and district level agencies, donors, the private sector, FBOs, NGOs and other representatives of civil society were consulted through a series of general meetings and working groups in developing NACP 3 strategies. This level of coordination is expected to continue through a process of joint monitoring and annual reviews.

There are several mechanisms to promote the "Three Ones" and GOI coordination with donors. The Expanded UN Theme Group brings together UN agencies and selected bilateral programs to exchange information and provide technical input to NACO through its sub-groups on technical issues. The Global Fund is supported by a small new Secretariat. The GFATM CCM is chaired by the Secretary of Health, MOHFW, supported by a large multisectoral committee that includes representation from the States and from a wide range of stakeholders, including USG. The vice-chair of the CCM is a Person Living with HIV/AIDS.

At the State level, USG programs in Tamil Nadu, Maharashtra and Andhra Pradesh have functioning systems for collaborating with the SACS and DACS that include representation on technical committees. At a lower level, projects interact with municipal authorities, ministry representatives, and community leaders. The demands on USG projects will increase under NACP 3 as responsibility for implementation devolves to a district team. Because coordination and collaboration requires relationship building, strengthening coordination in a vast country like India is a real practical challenge. As management of projects moves to the district level, new systems for coordination will need to be established.

5. Strategic Information

Surveillance

Under NACP 3, the plan is to organize key information, research and monitoring in a single strategic information unit at the national and state level. Surveillance has relied primarily on sentinel surveillance, and there is a need to expand sources of information to provide a better understanding of the epidemic. Survey methodology is not standardized, so it is difficult to compare and aggregate data.

The USG's vision for support of surveillance over the next five years includes:

Strengthening national surveillance systems: The USG will strengthen the national systems for HIV/AIDS surveillance and data collection through funding surveys, institutional strengthening, and skills training at both the national and state levels. The USG will work with the national Technical Working Group on Monitoring and Evaluation to strengthen protocols and develop strategies for surveillance that take into account the changing nature of the epidemic and the response (for example, PMTCT and ART scale up, and TB/HIV coordination). In particular, there is an opportunity to strengthen data collection on AIDS cases and mortality, to monitor the impact of treatment programs.

Improved use of data: The USG provides technical support to NACO and the states of Tamil Nadu and Andhra Pradesh in surveillance activities and use of information for evidence-based program planning. Under NACP 3, within the next five years, program implementation and planning will be decentralized to the district level, under the leadership of the SACS. There is a critical need to build the capacity of the SACS for this added responsibility. The USG will provide technical assistance and support staff positions at the

state level that will focus on strengthening surveillance and data to inform HIV/AIDS programming.

Funding and leveraging additional support for the National Family Health Survey (NFHS): The USG is collaborating with other donors to support the third round of NFHS. This will provide prevalence estimates of HIV in the general population (men and women) at the national level, for the six high-prevalence states, and in one highly vulnerable state, Uttar Pradesh. USG is supporting the survey as well the analysis, interpretation and dissemination of the results.

Strengthened technical approaches: The USG is also providing training and technical support to NACO and the National AIDS Research Institute (NARI) and other institutions to develop protocols for using the HIV incidence assay during sentinel surveillance and has initiated discussions with the Indian Council of Medical Research and NACO on strengthening surveillance systems to describe the epidemic genotypically. These projects will be coordinated closely with other partners including WHO, and the Gates and Clinton Foundations.

Monitoring viral resistance: With the introduction of antiretroviral therapy, it will be important to monitor resistance to specific drugs, and the USG is working with NACO and WHO to build capacity and develop guidelines and protocols in this area.

Monitoring and Evaluation

A national Technical Working Group on Monitoring and Evaluation (M&E) was established in 2005 under the principles of the "Three Ones." This group, in which USG is an active participant, is helping to develop the strategic information strategy for NACP 3. This includes recommendations on harmonizing indicators, methodologies for data collection and analysis, and the organizational structure for M&E at the national, district and state levels. At the state level, the USG has participated in a data working group that includes representatives from all of the major donor agencies and NGOs working in Tamil Nadu. The group has defined and developed a system to share data related to key indicators from all of their programs. Lessons learned will be shared nationally and expanded to other states.

There is a need to update the existing CMIS to include newer programs (e.g. PMTCT, ART) and to capture information from non-publicly funded projects. Greater attention needs to be paid to the quality and use of data. There is a critical need to promote, build capacity, and develop standardized systems for program evaluation. The USG's support to the national and state monitoring and evaluation system will:

- Provide ongoing technical support to assist in the design and implementation of the national plan for strategic information, M&E, and surveillance for NACP 3
- Provide technical support to build capacity for improved analysis and use of information particularly at the state level
- Expand existing web-based M&E tools used by implementing partner agencies that move data from the field up to program management level

- Continue to collaboration with NACO and other agencies to strengthen one M&E system, developing standardized indicators for GOI and donor programs
- Build capacity at the national and state level to design, implement, and assess program evaluations

USG will have more than 200 partners, so it is essential that we have a common monitoring system for our programs. In the next five years, USG agencies will review all our existing program indicators, ensure harmonization of definitions, establish a system for collection of information at the field level, and establish mechanism to provide ongoing feedback to programs and partners. We will work towards carrying out joint site visits and program reviews.

IV. Conclusion

The Emergency Plan provides exciting opportunities for the USG team to maximize the complementary skills, experience, and strategic approaches of the USG agencies. We will begin new processes of working together to harmonize our programs and technical assistance in the USG focus states, link programs where practical, and better share lessons learned, training opportunities, curricula and materials. A priority is working together to set up an internal monitoring and evaluation system. Interaction and decision-making among USAID, CDC, and ODC will be coordinated by the Emergency Plan Coordinator, under the leadership of the Ambassador.